DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FOLLOWING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL HEALTHCARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: SPA #02-07	2. STATE: Kansas
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2002	

5. TYPE OF PLAN MATERIAL (Check *One*):

☐ NEW STATE PLAN ■ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT
42 CFR 430.12	a. FFY 2002 $ 0 b. FFY 2003 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B #2.b., Pages 1-10	Attachment 4.19-B #4.b., Pages 1-8

10. SUBJECT OF AMENDMENT:

Rural Health Clinics - Methods & Standards for Establishing Payment Rates

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED: Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: Janet Schalansky BAL	16. RETURN TO: Janet Schalansky, Secretary Social & Rehabilitation Services Docking State Office Building 915 SW Harrison, Room 651S Topeka, KS 66612-2210
13. TYPED NAME: Janet Schalansky	
14. TITLE: Secretary	
15. DATE SUBMITTED: 03/20/02	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/22/02	18. DATE APPROVED: JUN 20 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/02	20. SIGNATURE OF REGIONAL OFFICIAL: Jackie Glaze for
21. TYPED NAME: Thomas W. Lenz	22. TITLE: ARA for Medicaid & State Operations

23. REMARKS:

cc:
Schalansky
Day/Haverkamp
CO
DSG/DIATA

SPA CONTROL

Date Submitted: 03/20/02
Date Received: 03/22/02

FORM HCFA-179 (07-92)

Instructions on Back

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

Effective January 1, 2001, rural health clinics enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. A RHC will be reimbursed using the alternative methodology only if the provider agrees to it. Under both options, reimbursement for services covered by Medicare shall be made through an all-inclusive encounter rate determined by the Medicare intermediary for each qualified encounter.

When a rural health clinic furnishes "other ambulatory services", the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all the requirements under the state plan are met. "Other ambulatory services" are those services which do not meet the Medicare definition of rural health clinic services, but are covered under the Medicaid state plan.

I. ENCOUNTER BILLING

A. Billable Visit or Encounter

A rural health clinic "visit" means a face-to-face encounter between a clinic patient and a clinic health care professional including a physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), nurse-midwife, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health care professional or multiple encounters with the same health professional on the same day shall constitute a single visit.

B. More Than One Encounter on the Same Day

If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional RHC visit.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

C. **Health Care Professional Requirement**

For services to be covered, the practitioner should either be an employee or an owner of the rural health clinic. A physician under contractual arrangement to receive compensation from the RHC also qualifies. The RN that performs KBH nursing assessments must be an employee of the RHC.

D. **Place of Service Criteria**

1. **Services at the Clinic**: Covered services provided at the clinic facility by practitioners defined in I(A) & I(B), excluding visiting nurse, may be billed as RHC visits. Services performed in the clinic are payable only to the clinic. Practitioners may not bill for these services under any other Medicaid provider number.
2. **Services Away from the Clinic**: Covered services provided at the patient's place of residence or elsewhere (e.g., at the scene of an accident) by an RHC practitioner excluding visiting nurse may be billed as a visit only if the practitioner is employed or compensated under agreement by the clinic for furnishing services to clinic patients in a location other than the clinic facility. These services are payable only to the RHC. The practitioner may not bill Medicaid for these services under any other provider number. If, on the other hand, the practitioner is NOT compensated by the RHC for provision of services in a location away from the clinic facility, services provided away from the clinic shall not constitute RHC services and the practitioner may bill Medicaid under a professional provider number. However, if these services are furnished during a time period for which he/she is compensated by the RHC, the clinic is required to carve out all expenditure associated with those services on the cost report.
3. **Services in a Hospital or a Skilled Nursing Facility**: Services provided by a clinic practitioner in outpatient, inpatient, or emergency room of a hospital, swing-bed, or in a SNF do not constitute RHC services under the Kansas Medicaid Program. These services may be billed under the practitioner's professional Medicaid provider number. However, if these services are provided by a clinic practitioner during a time period for which he/she is compensated by the RHC, the clinic must carve out all expenditure associated with these services on the cost report.

4. **Visiting Nurse Services**: Part time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter only if each of the following requirements is fulfilled:

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

(i) The RHC is located in an area designated by the Secretary of Health and Human Services as an area with a shortage of home health agencies;

(ii) the services are rendered to a homebound patient who is confined, either temporarily or permanently, to his or her place of residence as a result of a medical or health condition;

(iii) the "place of residence" may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital, long term facility, or skilled nursing facility (SNF) which is required to provide nursing care, rehabilitation, and other related services to inpatients as a condition for participation in Medicare & Medicaid SNF programs;

(iv) the services are furnished by a registered nurse (RN) or a licensed practical nurse (LPN) who is employed by or receives compensation from the RHC for providing these services;

(v) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the clinic. The treatment plan is:
- reviewed at least every 60 days by a supervising physician, and
- signed by a supervising physician, ARNP, or PA of the clinic;

(vi) the services consist of:
- nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
- personal care services to the extent covered under home health services. This does not include household & housekeeping services.

E. Content-of-Service

Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as RHC encounter nor as a service under any other Medicaid provider number. Examples of services that are content-of-service:

1. Services furnished by the auxiliary health care staff employed by the clinic that are "incident to" the services provided by the certified health care professionals.
2. Administration of vaccine, immunization, or other injection.
3. Professional component of Radiology or EKG if performed by a clinic health care professional.
4. Drugs and biologicals which cannot be self-administered.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

F. Exclusions

Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis & treatment of clinic patients are not covered. These should neither be billed as RHC visits nor reported on the cost report as allowable RHC expenditure. In addition, the following are not covered as RHC benefit:

1. All services furnished by the auxiliary health care staff who are not employed by the clinic.
2. Services provided by the RHC's auxiliary health care employees without direct supervision of a clinic practitioner.
3. Technical components of Radiology and EKG.
4. Clinical diagnostic laboratory services including the six required lab tests for RHC certification.
5. Health care services performed by outside entities, including those entities which are owned by the clinic's owner or staff. These include but are not limited to Lab, Radiology, EKG, Pharmacy, PT, and psychotherapy. The state plan requires that providers of these services bill Medicaid directly.

II. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program will implement the prospective payment system (PPS for rural health clinics to conform with BIPA 2000). There will be no retroactive cost settlements under this system. As an alternative to the PPS, providers will be offered the opportunity for reimbursement under a modified cost-based system (CBS) on facility fiscal year basis. This methodology combines features of a cost-based system with the PPS payment level mandated by BIPA. Under this system, RHCs will be paid the greater of cost-based or PPS-based reimbursement through retroactive settlements. To receive reimbursement under the alternative system for the duration of a specific facility fiscal year, providers will be required to submit written requests on a timely basis according to the schedule outlined in II.B.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

A. **Definitions**

1. **Rate** - Payment for each qualified encounter or visit.
2. **Base Years or FY 1 & FY 2 - Current Providers** - Facility fiscal years 1999 and 2000.
3. **Base Years or FY 1 & FY 2 - New Providers** - Two facility fiscal years subsequent to the first year of business as a rural health clinic.
4. **Cost-Based Rate or Payment** - Based on the Medicare cost report.
5. **Baseline Rate** - Average of cost-based rates from the base years.
6. **MEI** - Percentage increase in the Medicare Economic Index for primary care services.
7. **PPS Rate or Payment** - Meets PPS requirements outlined in the BIPA 2000.
8. **Non-PPS Rate or Payment** - Does not meet BIPA requirements.
9. **Preliminary** - Derives from the Medicare cost report for only one base year.
10. **Final or Finalized** - Derived from Medicare cost reports for both base years.

B. **Criteria for Election of the Alternative Payment Option**

1. **For Facility Fiscal Years Beginning Prior to October 1, 2001** - The request must be received in our office no later than July 27, 2001 or as decided by the state at a later time
2. **For Facility Fiscal Years Beginning On or After October 1, 2001** - The request should be received in our office no later than forty five (45) days prior to the beginning of the facility fiscal year.
3. **No Request Received** - If no request for the alternative payment option is received timely for a facility fiscal year, the provider will be reimbursed under the PPS for that entire fiscal year with no settlement.

C. **Cost Reports**

RHC providers shall not be required to submit cost reports to Medicaid. The agency will use finalized cost reports received from Medicare intermediaries.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

III. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, rural health clinics shall be paid prospective rates based on an average of the reasonable costs of providing covered RHC services during the base years, with no retroactive settlement.

A. Determination of PPS Baseline Rate

1. **Methodology** - It will depend on the times frames covered by an availability of cost reports as follows:
   (i) Both Base Years Full Twelve-Month Periods: (FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) /2.
   (ii) One or Both Base Years Less Than Twelve-Month Periods: [(FY 1 Cost-Based Rate x No. of Mo.)+(FY 2 Cost-Based Rate x No. of Mo.)] / Total No. of Months
   (iii) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.
   (iv) No Base Year Cost Report Available: The lower of current rate (eff. On 12/31/2000) or average of baseline rates of other RHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce.

2. **Frequency** - Once if the "final" rate is available at the time of initial rate setting, otherwise twice:
   (i) Initial Baseline Rate: After the approval of the SPA (for current providers) or at the time of enrollment (for new providers). This rate can be "preliminary" or "final" depending on the availability of cost reports.
   (ii) Final Baseline Rate: When Medicare cost reports for both base years become available.

B. Payment Procedure for January 1, 2001 to September 30, 2001

1. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/2000.
2. Upon SPA approval, initial PPS baseline rates will be computed using Medicare cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

F. **Adjustment for Laboratory**
Effective July 1, 2002, clinical diagnostic lab services furnished by a clinic are no longer within the scope of RHC services under the Kansas Medicaid Program. A RHC that provides this service will be reimbursed on fee-for-service basis. Medicare implemented this change effective January 1, 2001. SRS will retroactively adjust PPS rates effective 7/1/02 to exclude all expenses associated with laboratory services after receiving relevant data that facilitates identification of these expenditures.

G. **Change in Scope of Services**
To receive a PPS rate adjusted for a proposed increase or decrease in the scope of covered RHC services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditures, and change in total number of visits. Any rate change would be implemented on the first of the month following the SRS decision.

IV. ALTERNATIVE PAYMENT METHODOLOGY - "MODIFIED COST-BASED SYSTEM" (CBS)

Under this reimbursement system, interim payments shall be reconciled to the higher of cost-based or PPS-based amount through fiscal year end retroactive cost settlements.

A. **Payment Rates Effective January 1, 2001 to September 30, 2001**
Prior to CMS approval of this state plan amendment, Medicaid has continued to pay rates that were effective on December 31, 2000. These will be changed to PPS baseline rates when they are computed (see III.B.2).

B. **Payment Rates Effective October 1, 2001 to September 30, 2002**
Baseline rates effective on September 30, 2001 times the MEI index.

C. **Payment Rates Effective Each October 1 After September 30, 2002**
The PPS rates effective on the previous day (September 30 of the same year) adjusted for the MEI index.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

D. **Retroactive Cost Settlement**

1. **Cost-Based Medicaid Cost:** It is total reasonable cost of covered services furnished to eligible Program beneficiaries during the facility fiscal year. It will be determined by applying the cost-based rate from the Medicare cost report to total covered Medicaid visits obtained from the fiscal agent records.
2. **PPS-Based Medicaid Cost:** It is the amount that the provider would have received for covered services furnished to eligible Program beneficiaries during the facility fiscal year under the PPS option. It will be determined by applying the PPS rate(s) to total covered Medicaid visits.
3. **Total Payment Received by Provider:** It consists of Medicaid payment, third party liability, and HealthConnect payments obtained from fiscal agent records; and any other related transaction.
4. **Overpayment or (Underpayment):** The greater of cost-based or PPS-based Medicaid cost minus total payment received by the provider will be the settlement paid to or (due from) the provider.

V. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ENTITY (MCE)

If a RHC elects the alternative reimbursement option for a fiscal year, it will be eligible for a settlement on covered services provided to eligible Medicaid beneficiaries during that time period under a contract with a Medicaid managed care entity (MCE). The settlement will consist of the difference between the amount paid to the RHC by the MCE and the amount that would have been paid by Medicaid under the alternative methodology, Modified CBS, for the elected fiscal year.

A. **Quarterly Supplemental Payments**

The RHC shall send copies of the remittance advices received from the MCE to Medicaid after the end of each calendar quarter. Without these, the agency will not be able to make the supplemental payments. The remittances will be reviewed and the procedure-based payment data will be converted to "RHC encounters", making corrections if necessary (e.g., a payment not meeting the encounter definitions). The

state will compute "quarterly alternative amount" by applying the provider's Medicaid interim rate under the alternative system for the corresponding time period to total encounters. If it is less than the MCE payment, the agency will send the difference to the RHC no more than 90 days from the receipt of the remittance advices.

B. Fiscal Year End Settlement

When a fiscal year end final cost settlement is determined for Medicaid payments as described in section IV (Modified CBS), the state will also make a final settlement on services provided under the MCE contract during that FY. An "yearly alternative amount" will be computed using total encounters [obtained from the supplemental payment data] and the alternative system methodology. This amount will be compared with total payments received by the provider, i.e., MCE payments plus quarterly supplemental payments. If the computed alternative amount for the FY is higher than total payments, Medicaid shall pay the difference to the provider. If, on the other hand, the alternative amount is lower than total payments, the RHC shall refund the overpayment to the agency.